BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Michael Bennett Brenner, M.D. Physician's & Surgeon's Certificate No G 63953 Petitioner.	Case No.: 800-2019-058899

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Peter R. Osinoff, Esq., attorney for Michael Bennett Brenner, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on November 15, 2021.

IT IS SO ORDERED: November 15, 2021

Laurie Rose Lubiano, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Michael Bennett Brenner, M.D.** **Physician's & Surgeon's Certificate No. G 63953** **Respondent.**	**Case No. 800-2019-058899** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Peter R. Osinoff, Esq., on behalf of Respondent, Michael Bennett Brenner, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of November 5, 2021, at 5:00 p.m.

Execution is stayed until November 15, 2021, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: November 1, 2021

William Prasifka
Executive Director
Medical Board of California

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against, MICHAEL BENNETT BRENNER, M.D. 3950 Long Beach Blvd., Suite 200 Long Beach, CA 90807 Physician's and Surgeon's Certificate No. G 63953, Respondent.	Case No. 800-2019-058899 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On November 25, 2020, Complainant William Prasifka, in his official capacity as the Executive Director of the Medical Board of California (Board), filed Accusation No. 800-2019-058899 against Michael Bennett Brenner, M.D. (Respondent) before the Board.

2. On September 1, 1988, the Board issued Physician's and Surgeon's Certificate No. G 63953 to Respondent. That license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

3. On November 25, 2020, Andrea Geremia, an employee of the Complainant Agency, served by Certified Mail a copy of the Accusation No. 800-2019-058899, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5,

11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of the Accusation, the related documents, and Declaration of Service are attached as Exhibit B in the accompanying Default Decision Evidence Packet, and are incorporated herein by reference.

4. On November 28, 2020, according to the tracking information provided by the United States Postal Service website, a copy of Accusation No. 800-2019-058899, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 was received by someone at 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of a printout of delivery status of the copy of the Accusation, the related documents, and Declaration of Service are attached as Exhibit C in the accompanying Default Decision Evidence Packet, and are incorporated herein by reference

5. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

6. On March 3, 2021, Andrea Geremia, an employee of the Complainant Agency, served by Certified Mail a copy of the First Amended Accusation No. 800-2019-058899, Supplemental Statement to Respondent, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of the First Amended Accusation, the related documents, and Declaration of Service are attached as Exhibit D in the accompanying Default Decision Evidence Packet, and are incorporated herein by reference.

7. On March 5, 2021, according to the tracking information provided by the United States Postal Service website, a copy of the First Amended Accusation No. 800-2019-058899, Supplemental Statement to Respondent, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 was received by someone at 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of the Certified Mail green return receipt is attached as Exhibit E in the accompanying Default Decision Evidence Packet, and is incorporated herein by reference.

8. On March 18, 2021, Cynthia Gomez, an employee of the California Department of

Justice, served by First Class U.S. Mail, a copy of the Courtesy Notice of Default, a copy of the First Amended Accusation No. 800-2019-058899, Supplemental Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code section 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of the Courtesy Notice of Default, the related documents, and Declaration of Service are attached as Exhibit F in the accompanying Default Decision Evidence Packet, and in incorporated herein by reference.

9. On June 4, 2021, Dianne Richards, an employee of the Complainant Agency, served by Certified Mail a copy of the Second Amended Accusation No. 800-2019-058899, Supplemental Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of the Second Amended Accusation, the related documents, and Declaration of Service are attached as Exhibit G in the accompanying Default Decision Evidence Packet, and are incorporated herein by reference.

10. On June 7, 2021, according to the tracking information provided by the United States Postal Service website, a copy of the Seconded Amended Accusation No. 800-2019-058899, Supplemental Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 was delivered to the front desk/reception/mail room at 3950 Long Beach Blvd., Suite 200, Long Beach, CA 90807. A copy of a printout of delivery status of the copy of the Second Amended Accusation, the related documents, and Declaration of Service is attached as Exhibit H in the accompanying Default Decision Evidence Packet, and is incorporated herein by reference.

11. On June 28, 2021, Jasmine Zarate, an employee of the California Department of Justice, served by Certified U.S. Mail, a copy of the Courtesy Notice of Default, a copy of the Second Amended Accusation No. 800-2019-058899, Supplemental Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code section 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 3950 Long Beach

Blvd., Suite 200, Long Beach, CA 90807. A copy of the Courtesy Notice of Default, the related documents, and Declaration of Service are attached as Exhibit I in the accompanying Default Decision Evidence Packet, and in incorporated herein by reference.

12. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation and therefore waived his right to a hearing on the merits of Accusation No. 800-2019-058899.

13. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

14. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in exhibits A, B and C, finds that the allegations in Accusation No. 800-2019-058899 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Michael Bennett Brenner, M.D. has subjected his Physician's and Surgeon's Certificate No. G 63953 to discipline.

2. A copy of the Accusation and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Medical Board of California is authorized to revoke Respondent's Physician's and Surgeon's Certificate based upon the following violations alleged in the Accusation:

a. Gross Negligence: Respondent committed gross negligence by failing to maintain accurate and complete medical records, including physical exams, surgical notes, as well

as treatment plans and objectives, and informed consent forms for Patient 1 for a minimum of seven years following discharging Patient 1. Patient 1 was last seen by Respondent in January of 2016. Board investigators requested medical records for Patient 1 in 2019 and Respondent stated he did not have them. Respondent's office receptionist told Board investigators that the records had not been purged. Respondent committed gross negligence in either purging Patient 1's records too soon or refusing to cooperate in a Board investigation. Respondent's acts are in violation of section 2234, subdivision (b), of the Code. (See Exhibits J, L, and S attached in the accompanying Default Decision Evidence Packet and incorporated herein);

b. Repeated Negligent Acts: Respondent committed repeated negligent acts in that he: (1) failed to refer Patient 2 to a retina specialist in a timely manner for management of his dislocated intraocular lens; and (2) failed to appropriately manage Patient 2's post-operative hyphemia. Respondent's acts are in violation of section 2234, subdivision (c), of the Code. (See Exhibits J, L, and S attached in the accompanying Default Decision Evidence Packet and incorporated herein);

c. Inadequate Medical Recordkeeping: Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1 and 2. Respondent's acts are in violation of section 2266 of the Code. (See Exhibits J, L, and S attached in the accompanying Default Decision Evidence Packet and incorporated herein);

d. Failure To Pay Civil Penalties: Respondent failed to respond to two Notifications of Violations and Imposition of Civil Penalties, case numbers 800-2019-058899 and 800-2020-063744, neither requesting a hearing on the Notifications nor paying the Civil Penalties. Respondent's acts are in violation of section 2225.5 of the Code. (See Exhibits J, L, M, N, O, and P attached in the accompanying Default Decision Evidence Packet and incorporated herein);

e. Failure To Comply with a Board Order Issued Under Section 820 of the Code: Respondent failed to comply with a Board Order issued under section 820 of the Code when he failed to appear for two previously scheduled physical and mental examinations ordered by the Board under section 820 of the Code. Respondent's acts are in violation of section 821 of the

Code. (See Exhibits J, K, L, Q, and R attached in the accompanying Default Decision Evidence Packet and incorporated herein);

f. Unprofessional Conduct: Respondent committed unprofessional conduct by: (1) committing gross negligence in the care and treatment of Patient 1; (2) committing repeated negligent acts in the care and treatment of Patient 2; (3) failing to maintain adequate and accurate records of his care and treatment of Patients 1 and 2; (4) Notifications of Violations and Imposition of Civil Penalties, case numbers 800-2019-058899 and 800-2020-063744, neither requesting a hearing on the Notifications nor paying the Civil Penalties; and (5) failing to comply with a Board order issued under Section 820 of the Code by failing to appear for two previously scheduled physical and mental examinations ordered by the Board under section 820 of the Code. Respondent's acts are in violation of section 2234, subdivision (a), of the Code. (See Exhibits J, K, L, M, N, O, P, Q, R, and S attached in the accompanying Default Decision Evidence Packet and incorporated herein)

ORDER

IT IS ORDERED THAT Physician's and Surgeon's Certificate No. G 63953, heretofore issued to Respondent Michael Bennett Brenner, M.D., is revoked.

IT IS ALSO ORDERED THAT Respondent Michael Bennett Brenner, M.D. pay twenty thousand dollars ($20,000) in civil penalties to the Board.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

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This Decision shall become effective on NOV 0 5 2021.

It is so ORDERED OCT 0 8 2021

WILLIAM PRASIFKA
EXECUTIVE DIRECTOR
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **Michael Bennett Brenner, M.D.** **3950 Long Beach Blvd., Suite 200** **Long Beach, CA 90807-5412** **Physician's and Surgeon's Certificate No. G 63953,** Respondent.	Case No. 800-2019-058899 **SECOND AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Second Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 1, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number G 63953 to Michael Bennett Brenner, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

3. On or about February 18, 2020, the Medical Board issued an order pursuant to Business and Professions Code section 820 compelling Respondent to undergo mental and

physical examinations. It appeared to the Board that Respondent may be unable to practice medicine safely because his ability to practice is impaired due to mental illness or physical illness affecting his competency. The examinations were ordered to be conducted no later than thirty (30) days from February 18, 2020, the date of service of the order.

JURISDICTION

4. This Second Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 820 of the Code states:

> Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822.

6. Section 821 of the Code provides that the licentiate's failure to comply with an order issued under section 820 shall constitute grounds for the suspension or revocation of the licentiate's certificate or license.

7. Section 2225 of the Code states:

> (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c)(1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to

illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

8. Section 2225.5 of the Code states:

(a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 30th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. For health care facilities that have electronic health records, failure to provide the authorizing patient's certified medical records to the board within 15 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid

by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For purposes of this section, certified medical records means a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

(g) For purposes of this section, a "health care facility" means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

9. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or

abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL ALLEGATIONS

11. On January 18, 2019, the Board received an 805 report from the Surgery Center of Long Beach stating that Respondent failed to participated in an investigative process to confirm his ability to practice medicine safely, which resulted in the termination of his medical staff privileges.

12. The Board served a subpoena duces tecum on the Surgery Center of Long Beach and received two patient records for Patients 1 and 2.[1] Patients 1 and 2 agreed to be interviewed by the Board and signed record release forms for their medical records to be reviewed.

13. Patient 1 is a 79 year-old female. Patient 1 had left eye cataract surgery performed by

[1] Patient names are anonymized based on privacy concerns.

Respondent on January 13, 2016. Patient 1 returned the following day for a follow-up appointment and Respondent informed Patient 1 that the lens had broken in her eye. During that follow-up appointment, Respondent attempted to remove the lens, having his wife hold down Patient 1's head as he tried to remove the lens from the eye. Respondent was unsuccessful and referred Patient 1 to see Dr. R, a retina specialist.

14. Patient 1 went to see Dr. R. on January 15, 2016 where Dr. R. performed a pars plana vitrectomy[2] and lensectomy surgery[3] to remove the broken lens in Patient 1's eye. On February 18, 2016, Patient 1 returned to Dr. R's office and saw Dr. G, who is in the same practice as Dr. R, and performed a repair of Patient 1's retinal detachment with scleral buckle,[4] pars plana vitrectomy, and used silicone oil in her left eye. On June 27, 2016, Dr. G. removed the silicone oil from Patient 1's left eye and performed a membrane peel.[5] On February 26, 2018, Dr. G. referred Patient 1 to Dr. S. for management of glaucoma in Patient 1's left eye. Dr. S's last chart note from May 13, 2019, noted that Patient 1 had 20/80 vision and normal intraocular pressure on multiple glaucoma eye drops in her left eye.

15. A Board investigator sent a request for Patient 1's medical records to Respondent's office. On May 30, 2019, a Board investigator received a Certification of No Records from Respondent's office in response to a request for Patient 1's medical records. However, during an unannounced visit to Respondent's office on August 20, 2019, Board investigators spoke with Respondent's office receptionist, Katrina Rodriguez, who stated Patient 1's medical records had not been purged.

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[2] Pars plana vitrectomy is a commonly employed technique in vitreoretinal surgery that enables access to the posterior segment of the eye for treating conditions such as retinal detachments, vitreous hemorrhage, endophthalmitis, and macular holes in a controlled, closed system.

[3] Lensectomy surgery is a microsurgery procedure that removes part or all of the crystalline lens from the eye.

[4] A scleral buckle is a piece of silicone sponge, rubber, or semi-hard plastic that an ophthalmologist places on the outside of the eye (the sclera, or the white of the eye). The material is sewn to the eye to keep it in place. The buckling element is usually left in place permanently.

[5] An epiretinal membrane peel is an advanced procedure used to remove scar tissue over the macula, the central part of the eye's retina responsible for near, detailed vision. An epiretinal membrane peel is performed in conjunction with vitrectomy surgery.

16. Patient 2 is an 82-year-old male. Patient 2 saw Respondent on August 3, 2017, and was diagnosed with narrow anterior chamber angles. Respondent performed prophylactic laser treatments in both eyes to prevent glaucoma within the next few weeks. Patient 2 complained of decreased vision in his right eye over several months. On November 9, 2017, Respondent performed cataract surgery on Patient 2.

17. The vision in Patient 2's left eye was also worsening. Respondent performed cataract surgery on Patient 2's left eye on May 10, 2018. The capsular complex dislocated in Patient 2's left eye complicating the cataract surgery. After the surgery, Patient 2 had hyphema, blood in the anterior chamber of his left eye.

18. Patient 2 saw Dr. K., a retina specialist, on June 11, 2018 and Dr. H., a cornea specialist, on June 14, 2018. The specialists performed pars plana vitrectomy, IOL explantation, and corneal transplantation on June 21, 2018. Patient 2 continued to have retinal problems including subretinal fluid. Additional surgery was discussed with Patient 2, but he decided not to have any further surgery because of the poor overall prognosis of any improvement in his vision. Patient 2's last visit with a retina specialist on March 21, 2019, noted that his visual acuity was stable.

19. Respondent did not provide any post-operative notes after the cataract surgery he performed on Patient 2's left eye on May 10, 2018. Patient 2's initial visit with Dr. K. was on June 11, 2018. Respondent provided a referral letter to Dr. K. dated May 29, 2018. The date of the referral letter is 19 days after Respondent's cataract surgery on Patient 2's left eye. By the time Patient 2 saw Dr. K., 32 days had elapsed since the surgery. An earlier referral could have improved Patient 2's visual outcome.

20. On May 21, 2019, a Board investigator sent Respondent a request via U.S. Certified Mail and facsimile requesting Patient 2's medical records. No response was received from Respondent. A follow-up request was sent to Respondent on June 18, 2019, by U.S. Certified Mail and regular mail. A Board investigator also called Respondent's office and spoke with the office receptionist, Katrina Rodriguez, who confirmed Respondent had received the earlier request for Patient 2's medical records and was aware of the possible civil penalty if he did not

comply. No response was received from Respondent to the follow-up letter. A final letter was sent to Respondent on July 1, 2019, requesting Patient 2's medical records. Ultimately, Respondent failed to produce any medical records for Patient 2 to the Board.

21. On December 26, 2019, the Board filed a Notification of Violations and Imposition of Civil Penalties against Respondent for his failure to provide Patient 2's medical records. It was sent to Respondent via Certified and First Class U.S. Mail. The Notification stated it "is final and effective (15) days from the date this Notification is served upon Respondent, unless Respondent requests a hearing within the fifteen-day period." No response was received from Respondent.

22. On April 9, 2020, a Board Investigator personally served the Notification on Respondent at his office. No response was received from Respondent.

23. On September 2, 2020, the Board filed a Notification of Violations and Imposition of Civil Penalties against Respondent. It was sent to Respondent via Certified and First Class U.S. Mail. The Notification stated it "is final and effective (15) days from the date this Notification is served upon Respondent, unless Respondent requests a hearing within the fifteen-day period." No response was received from Respondent.

24. On September 9, 2020, the Board received a signed Certified U.S. Mail return receipt for the Notification of Violations and Imposition of Civil Penalties sent to Respondent's address of record in Long Beach, California. The return receipt listed the delivery date as September 5, 2020, and confirmed it was received by an adult. No response was received from Respondent.

25. On or about February 18, 2020, acting on reports that Respondent appeared to be mentally or physically ill, the Board issued an order pursuant to Business and Professions Code section 820, Case No. 800-2018-048328, compelling Respondent to undergo mental and physical examinations to determine whether he was impaired by a mental or physical illness affecting his competency to practice medicine.

26. On or about April 9, 2020, two Board Investigators with the Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit, personally served Respondent with the Board's order compelling Respondent to undergo mental and physical examinations.

27. On or about April 9, 2020, a Board Investigator sent Respondent a notice of appointments, confirming appointments with Dr. Hosea Brown for a physical examination on May 1, 2020, at 1:00 pm and Dr. Nathan Lavid for a mental examination on May 8, 2020, at 9:00 am.

28. On or about April 29, 2020, Respondent called Dr. Brown to reschedule his physical examination. Respondent stated that he wanted to reschedule his exam for June 19, 2020, due to multiple vague concerns, one of them regarding the coronavirus. Dr. Brown encouraged Respondent to appear for his May 1, 2020, appointment by assuring Respondent that he would be the only patient evaluated in the office that day and that Dr. Brown would be adhering to all appropriate precautions and preventive measures concerning the coronavirus. Dr. Brown informed Respondent that he would be utilizing masks and gloves and observing all appropriate sterilization techniques. Despite Dr. Brown's assurances, Respondent refused to appear for his May 1, 2020, appointment and rescheduled the appointment for June 19, 2020. Respondent did not appear for his May 1, 2020, appointment and did not appear for his rescheduled appointment on June 19, 2020, with Dr. Brown.

29. On or about May 7, 2020, Respondent called Dr. Lavid's office and left a voicemail. In the voicemail, he informed Dr. Lavid that he would not be appearing for his May 8, 2020, appointment. Respondent stated that he would not appear for the appointment due to Los Angeles County's Coronavirus Shelter-In-Place order and wanted to postpone his appointment to late June. Respondent did not appear for his May 8, 2020, appointment with Dr. Lavid and did not reschedule his appointment.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

30. By reason of the facts and allegations set forth in paragraphs 11 through 15 above, Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for acts or omissions involving gross negligence in the maintaining of Patient 1's medical records. The circumstances are as follows:

a. The standard of care requires that a physician maintain accurate and complete

medical records, including physical exams, surgical notes, as well as treatment plans and objectives, and informed consent forms. Health and Safety Code section 123145 requires providers of health services to preserve records for a minimum of seven years following discharge of a patient.

b. The Board requested the medical records of Patient 1. On May 30, 2019, a Board investigator received a Certification of No Records from Respondent's office in response to the Board's request for Patient 1's records. In a letter to a Board investigator dated July 16, 2019, Respondent stated, "There are no records reproducible from my office as per the statutes of time limitations and the antecedent transfer of care...."

c. However, on August 20, 2019, Board investigators made an unannounced visit to Respondent's office and spoke with the office receptionist. The office receptionist stated that Patient 1's records had not been purged.

d. Respondent either did not have the medical records or chose not to produce them to Board investigators. In either instance, Respondent committed gross negligence in either purging Patient 1's records too soon or refusing to cooperate in a Board investigation.

31. Respondent's acts and/or omissions as set forth in paragraphs 11 through 15 above, whether proven individually, jointly, or in any combination thereof, constitutes gross negligence, pursuant to Section 2234, subdivision (b), of the Code.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

32. By reason of the facts and allegations set forth in paragraphs 16 through 19 above, Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of Patient 2. The circumstances are as follows:

a. Respondent did not refer Patient 2 to a retina specialist in a timely manner for management of his dislocated intraocular lens.

b. Respondent did not appropriately manage Patient 2's post-operative hyphema. There are no medical records from Respondent's office for Patient 2's post-operative period.

Notes from Dr. K. indicate that Patient 2 suffered from near total hyphema and that Patient 2 stated to Dr. K. that Respondent drained the blood from his eye multiple times in his office. Draining blood from the eye should be performed in an operating room for sterility and with the use of proper instruments to remove the blood in a controlled manner.

33. Respondent's acts and/or omissions as set forth in paragraphs 16 through 19 above, whether proven individually, jointly, or in any combination thereof, constitutes repeated negligent acts, pursuant to Section 2234, subdivision (c), of the Code.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Medical Recordkeeping)

34. By reason of the facts and allegations set forth in paragraphs 11 through 19 above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1 and 2.

35. The facts and allegations detailed in paragraphs 11 through 19 above are incorporated herein by reference as if fully set forth.

36. Respondent's acts and/or omissions as set forth in paragraphs 11 through 19 above, whether proven individually, jointly, or in any combination thereof, constitutes unprofessional conduct, pursuant to Section 2234, subdivision (a), of the Code.

FOURTH CAUSE FOR DISCIPLINE

(Failure To Pay Civil Penalties)

37. By reason of the facts set forth in paragraphs 20 through 24 above, Respondent's license is subject to disciplinary action under section 2225.5 of the Code in that Respondent failed to respond to two Notifications of Violations and Imposition of Civil Penalties, case numbers 800-2019-058899 and 800-2020-063744. The circumstances are as follows:

38. The facts detailed in paragraphs 20 through 24 are incorporated herein by reference as if fully set forth.

39. Respondent's acts and/or omissions as set forth in paragraphs 20 through 24 above, whether proven individually, jointly, or in any combination thereof, constitutes Respondent's failure to respond to the two Notifications of Violations and Imposition of Civil Penalties, case

numbers 800-2019-058899 and 800-2020-063744, in violation of Section 2225.5 of the Code.

FIFTH CAUSE FOR DISCIPLINE

(Failure To Comply With An Order Issued Under Section 820 Of The Code)

40. By reason of the facts set forth in paragraphs 25 through 29 above, Respondent's license is further subject to disciplinary action under Section 821 of the Code in that Respondent failed to comply with a Board order issued under Section 820 of the Code by failing to appear for two previously scheduled physical examinations ordered by the Board under Section 820 of the Code. The circumstances are as follows:

41. The facts detailed in paragraphs 25 through 29 above are incorporated herein by reference as if fully set forth.

42. Respondent's acts and/or omissions as set forth in paragraphs 25 through 29 above, whether proven individually, jointly, or in any combination thereof, constitutes Respondent's failure to comply with an order issued under Section 820 of the Code, pursuant to Section 821 of the Code.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional conduct)

43. By reason of the facts and allegations set forth in paragraphs 11 through 42 above, Respondent's license is further subject to disciplinary action under Section 2234, subdivision (a), of the Code in that Respondent (1) committed gross negligence in the care and treatment of Patient 1; (2) committed repeated negligent acts in the care and treatment of Patient 2; (3) failed to maintain adequate and accurate records of his care and treatment of Patients 1 and 2; (4) failed to respond to two Notifications of Violations and Imposition of Civil Penalties, case numbers 800-2019-058899 and 800-2020-063744; and (5) failed to comply with an order issued under Section 820 of the Code by failing to appear for two previously scheduled physical examinations ordered by the Board under Section 820 of the Code. The circumstances are as follows:

44. The facts and allegations detailed in paragraphs 11 through 42 above are incorporated herein by reference as if fully set forth.

45. Respondent's acts and/or omissions as set forth in paragraphs 11 through 42 above,

whether proven individually, jointly, or in any combination thereof, constitutes unprofessional conduct, pursuant to Section 2234, subdivision (a), of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Ordering Michael Bennett Brenner, M.D. to pay twenty thousand dollars ($20,000) in civil penalties to the Board;

2. Revoking or suspending Physician's and Surgeon's Certificate Number G 63953, issued to Michael Bennett Brenner, M.D.;

3. Revoking, suspending or denying approval of Michael Bennett Brenner, M.D.'s authority to supervise physician assistants and advanced practice nurses;

4. Ordering Michael Bennett Brenner, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: JUN 04 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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